



ORTHODONTIC LABORATORIES, INC.

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 Independence, MO 64052
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 www.royalortholabs.com

DATE SENT _____ DATE WANTED _____

DOCTOR _____
 ADDRESS _____
 TELEPHONE (____) _____
 CITY _____ STATE _____ ZIP _____
 PATIENT _____ AGE _____

RETAINER & FIXED PRESCRIPTION

Please check:

- | RETAINER | Upper | Lower |
|---|--------------------------|--------------------------|
| Hawley-Standard | <input type="checkbox"/> | <input type="checkbox"/> |
| Hawley Spring Ret. | <input type="checkbox"/> | <input type="checkbox"/> |
| Spring Ret. (3x3) | <input type="checkbox"/> | <input type="checkbox"/> |
| Invisible/Essix | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> .030 <input type="checkbox"/> .060 | | |
| Flipper Partial | <input type="checkbox"/> | <input type="checkbox"/> |
| Soft Mouthguard | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleaching Trays | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | | |

FIXED APPLIANCES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Space Maintainer | <input type="checkbox"/> Distal Shoe |
| <input type="checkbox"/> Transpalatal Arch | <input type="checkbox"/> Nance |
| <input type="checkbox"/> Habit Appliance | <input type="checkbox"/> Quad Helix |
| <input type="checkbox"/> Space Regainer | <input type="checkbox"/> Hyrax RPE |
| <input type="checkbox"/> Bonded RPE | <input type="checkbox"/> Haas RPE |
| <input type="checkbox"/> Distal Jet | <input type="checkbox"/> Williams |
| <input type="checkbox"/> Other _____ | |
-
- | | | |
|---|-------------------------------------|--------------------------------|
| Lingual Arch | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> 1x1 Bonded | <input type="checkbox"/> 2x2 Bonded | |
| <input type="checkbox"/> 3x3 Bonded | <input type="checkbox"/> 4x4 Bonded | |
| <input type="checkbox"/> 5x5 Bonded | <input type="checkbox"/> 6x6 Bonded | |
| <input type="checkbox"/> Without Adjustment Loops | | |
| <input type="checkbox"/> With Adjustment Loops | | |
| <input type="checkbox"/> Cross-Palatal Lingual Wire | | |
| <input type="checkbox"/> Lingual Bar to Cingulum | | |
| <input type="checkbox"/> Lingual Bar to Middle 1/3 of Teeth | | |
| <input type="checkbox"/> Lingual Bar to Line on Cast | | |
| <input type="checkbox"/> Brackets (Specify) _____ | | |

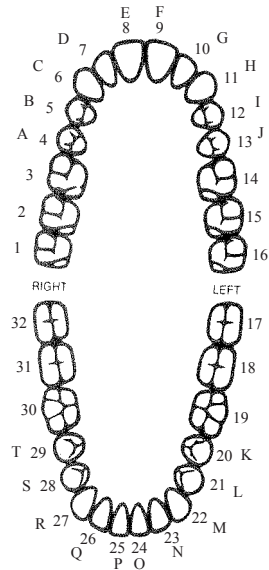
R _____

(Use reverse side for comments)

- | | |
|---|--|
| RESET TEETH CIRCLED | LABIAL WIRE |
| R $\frac{3}{3} \frac{2}{2} \frac{1}{1} \frac{1}{1} \frac{2}{2} \frac{3}{3}$ L | <input type="checkbox"/> 2x2 (No Loops) |
| <input type="checkbox"/> Add Lingual Spring | <input type="checkbox"/> 3x3 (W/Loops) |
| | <input type="checkbox"/> Wraparound |
| | <input type="checkbox"/> Soldered Flat (3x3) |

- | | |
|---|--|
| ACRYLIC OPTIONS | CLASPS/SPRINGS |
| <input type="checkbox"/> Anterior Bite Plane | <input type="checkbox"/> Ball |
| <input type="checkbox"/> Posterior Bite Plane | <input type="checkbox"/> Arrow |
| <input type="checkbox"/> No Bite Plane | <input type="checkbox"/> "C" Clasps |
| <input type="checkbox"/> Full Palate | <input type="checkbox"/> Adams |
| <input type="checkbox"/> Horseshoe Palate | <input type="checkbox"/> Soldered "C"s |
| <input type="checkbox"/> Add Expansion Screw | <input type="checkbox"/> Molar Rests |
| <input type="checkbox"/> Add Tongue Crib | <input type="checkbox"/> Finger Spring |
| <input type="checkbox"/> Add Pontic(s) | <input type="checkbox"/> Sweep Wire |
| Shade _____ | <input type="checkbox"/> Z-Spring |

UPPER COLOR _____



LOWER COLOR _____

DR'S SIGNATURE: (Required by law)

LICENSE NO.

PLEASE SEND Boxes Prescription Forms Labels